

than the current per bed standard. Documentation of the legally enforceable, arms length agreement must be submitted with the cost report in which the additions or improvements are reported.

- (2) In no other circumstances other than in (1)(a) and (1)(b) above shall a provider's total asset value under FRVS exceed their current per bed standard.
- (3) Any cost associated with capital additions or improvements which are not recognized in the FRVS rate due to the per bed standard limitation, shall not be allowed in any future FRVS rate.

Adjustments made to FRVS rates due to capital additions or improvements shall be subject to retroactive adjustment based on audit findings made by AHCA. For facilities with 5 to 10 years remaining to full FRVS phase-in, 50 percent of replacement cost shall be reimbursed as a pass-through cost as depreciation and interest expense; if 4 years are remaining in the phase-in, 40 percent; if 3 years remaining, 30 percent; 2 years remaining, 20 percent; and 1 year remaining, 10 percent. This pass-through reimbursement shall be recaptured by AHCA in entirety if the facility undergoes a change of ownership.

- 2. FRVS for facilities entering the Medicaid program subsequent to October 1, 1985.
  - a. The FRVS rate for facilities constructed subsequent to October 1, 1985 or existing facilities which enter the Medicaid program subsequent to October 1, 1985 shall be calculated as in 1.a.-h. and j. above. These facilities shall not be subject to any phase-in to the FRVS rate, and shall not have the option to elect reimbursement under Section III. G. 2. - 5.

- b. The ceiling that shall apply to facilities entering the program subsequent to October 1, 1985 shall be the ceiling in effect 6 months prior to the date the facility was first put into service as a nursing home. For facilities built prior to October 1, 1985 which enter the program subsequent to October 1, 1985, the ceiling at October 1, 1985 shall be deflated, using the FCCI Index, back to 6 months prior to the date the facility was first put into service as a nursing home.
- 3. Facilities that are currently participating in the Medicaid program but subsequently withdraw.
  - a. Facilities that participate in the Medicaid program on or after October 1, 1985 but subsequently withdraw shall be subject to the same cost per bed ceiling that they were previously subject to should they decide to re-enter the program.
  - b. At re-entry into the program, the indexing of asset valuation shall resume at the point where the facility was in the 40-year indexing curve per E.1.c. above when it withdrew from the program.
- 4. Property reimbursement for facilities upon change of ownership.
  - a. Facilities that undergo a change of ownership on or after October 1, 1985 shall be reimbursed for property based upon the provisions contained in this section. It is the Agency's intent that, to the extent possible, the new provider shall receive essentially the same reimbursement for property costs as the previous provider. Therefore, unless stated otherwise in b. through f. below, the new provider's reimbursement shall be based on 1.-3. above.
  - b. If the previous owner of a facility was being paid depreciation plus interest under the hold harmless provision of 1.h. above, the new owner shall also receive depreciation plus interest per Section III.G. unless he requests the

Agency, in writing, to begin FRVS payments instead. The FRVS depreciable basis shall remain the same as that of the previous owner; interest expense allowed, subject to the limitations in 1.f. above.

- c. If the previous owner was being reimbursed under FRVS, the new owner shall also receive FRVS payment, entering at the point of phase-in and asset value indexing that the previous owner had reached. If the new owner's principal balance of all current mortgages is less than 60 percent of the indexed asset value, only the interest portion, at a rate determined in 1.f.(4), will be used in calculating the new owner's FRVS rate. If the new owner's principal balance of all current mortgages is equal to or greater than 60 percent of the indexed asset value, then the new owner shall be paid principal and interest on 80 percent of the total asset valuation amortized over 20 years at the interest rate specified in 1.f.(1) above. In addition, the new owner's interest rate shall be used in lieu of the original owner's interest rate in accordance with the limitations described at 1.f.(1). above. Any credits accrued by the previous owner for indexing as described in 1.b. above shall be applied to the new owner.
- d. The return on equity or use allowance shall be calculated as per 1.e. above. A per diem shall be calculated for property taxes and insurance, based upon actual historic cost and patient days shown in the latest applicable cost report, as per 1.e. above.
- e. The new provider shall be subject to the recapture provisions in Section III.H. of this plan. The new provider's cost basis shall be computed per III.G.3. of this plan.
- f. Reimbursement to a new provider for costs of replacement equipment shall be governed by the same provisions affecting the previous provider. The new provider shall enter the phase-in schedule at the point reached by

the previous provider at the change of ownership, and shall be reimbursed per 1.j. above for replacement costs.

5. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Medicaid certification effective on or after July 1, 1991.

	Example 1	Example 2
New Facility Cost	\$3.0 Million	\$4.0 Million
CON Approval	\$2.8 Million	\$3.0 Million
Medicaid Allowable Cost	\$2.5 Million	\$3.5 Million
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Reimbursable Cost	\$2.5 Million	\$3.0 Million

Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example above, the reimbursable cost which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Medicaid allowable cost.

F. Medicaid Adjustment Rate (MAR)

For rate periods beginning on and after July 1, 1996, the Medicaid Adjustment Rate shall be calculated as follows:

1. Facilities with 90% or greater Medicaid utilization shall have their MAR equal their WBR as determined in the formula below.
2. Facilities with 50% or less Medicaid utilization shall receive no MAR.
3. Facilities between 50% and 90% Medicaid utilization shall have their MAR as determined by the following formula:

$$\begin{aligned}\text{MAR} &= \text{WBR} \times \text{MA} \\ \text{WBR} &= (\text{BR} \times \text{MAW}) \times ((\text{Superior} + \text{Standard})/\text{All}). \\ \text{MA} &= ((\text{Medicaid Utilization \%} - \text{MIN})/(\text{MAX}-\text{MIN})) \times 100\end{aligned}$$

**Definitions:**

**MAR** = Medicaid Adjustment Rate  
**WBR** = Weighted Base Rate  
**MA** = Medicaid Adjustment  
**BR** = Base Rate, which is set as the results of step V.B.19.e  
**MAW** = Medicaid Adjustment Weight, which is set at .045  
**Superior** = Number of Superior Days as described in section V.D.2.(a)  
**Standard** = Number of Standard Days as described in section V.D.2.(a)  
**All** = All superior, standard, and conditional days  
**MIN** = Minimum Medicaid Utilization Amount which is set at 50%  
**MAX** = Maximum Medicaid Utilization Amount which is set at 90%

The result of these calculations will represent the **MAR** to which the provider is entitled. This rate is to be included in the patient care component of the provider's total reimbursement rate.

G. Case-Mix Adjustment

For the rate period beginning on April 1, 1999 through June 30, 1999 and for rate periods beginning on and after July 1, 1999, a case-mix adjustment will be calculated and paid as an add-on to the patient care component of the per diem rate.

- A. 1. AHCA will utilize the Minimum Data Set (MDS) Assessments being submitted by nursing facilities to calculate an average case-mix score for each nursing facility participating in the Medicaid program. The average case-mix score will be computed by using the most current version Resource Utilization Grouper (RUGS III), as published by HCFA, to classify the MDS assessments into one of thirty-four (34) RUGS III categories. An additional category will be added as a default, which will be assigned the lowest case-mix weight, for those MDS assessments that can not be classified. For purposes of calculating

the case-mix score only MDS assessments for Medicaid residents will be utilized to establish the average case-mix score.

- a. For the rate period April 1, 1999 through June 30, 1999 the MDS assessments filed for the period October 1, 1998 through February 28, 1999 will be used to calculate the average case-mix score. For each July 1 and January 1 rate period subsequent to June 30, 1999 the MDS assessments submitted for the periods October 1 through March 31 and April 1 through September 30, respectively, will be used in the calculation of the average case-mix score.
- b. For the applicable periods as described in Section V.G.1.a. above a case-mix score will be calculated for each MDS assessment submitted for a Medicaid resident. The total case-mix score for each resident will be weighted by the number of days covered by the MDS assessment. Upon computing each individual's weighted case-mix score an average case-mix score will be computed for the facility using all Medicaid residents.
- c. An average case-mix score will be calculated for all nursing facilities participating in the Medicaid program as of April 15 and October 15 preceding the July 1 and January 1 rate semesters, respectively. New providers, as defined in V.G.1.d. below, entering the Medicaid program subsequent to the April 15 and October 15 dates will not receive a case-mix adjustment until the following January 1 and July 1 rate semesters, respectively. For the rate period April 1, 1999 through June 30, 1999 only those nursing facilities participating in the Medicaid program as of February 28, 1999 will receive a case-mix adjustment to the patient care component of their total reimbursement rate.
- d. For new providers entering the Medicaid program the average case-mix score will be the minimum established under Section V. G. 2.a.below.

New providers, for purposes of calculating the case-mix adjustment, are those in a newly constructed nursing facility or nursing facilities which have not previously participated in the Medicaid program. For existing providers undergoing a change in ownership or operator the MDS assessments submitted for the previous Medicaid provider will be used to establish the average case-mix score for the new provider.

- e. No changes or corrections to the case-mix adjustment paid to a nursing facility will be made subsequent to the effective date of the case-mix adjustment.
2. The case-mix adjustment to the patient care component of the total per diem rate will be calculated using the following methodology.
- a. Upon calculating the average case-mix score for each nursing facility eligible for the case-mix adjustment, a statewide average case-mix score will be computed. The statewide average case-mix score will be the average case-mix score for all facilities eligible for the case-mix adjustment. The lowest case-mix score will be used as the minimum score for new providers, as described in V.G.1.d. above.
  - b. An average case-mix rate will be used to calculate each facility's add-on and will be calculated by dividing the available dollars appropriated for the case-mix adjustment by the projected number of Medicaid days in the prospective rate period. For the April 1, 1999 case-mix adjustment the prospective period will be April 1, 1999 through June 30, 1999.
  - c. The add-on for each individual facility will be computed by multiplying the average case-mix rate determined in Section V.G.2.b. above times each facility's average case-mix score in Section V.G.2.a. above divided by the statewide average case-mix score, calculated in Section V.G.2.a. above.

- d. If in total the add-on for each facility times that facility's projected Medicaid days does not equal the total funds appropriated for the case-mix add-on, then each facility's add-on will be proportionately adjusted to ensure that total payments for the case-mix add-on equals the available funds.

VI. Payment Assurance

The State shall pay each nursing home for services provided in accordance with the requirements of the Florida Title XIX State Plan, Rule 59, F.A.C., 42 CFR (1997), and Section 1902 of the Social Security Act. The payment amount shall be determined for each nursing home according to the standards and methods set forth in the Florida Title XIX Long-Term Care Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of nursing homes in the Medicaid Program, the availability of high-quality nursing home services for recipients, and for services, which are comparable to those available to the general public.

VIII. Payment in Full

Any provider participating in the Florida Medicaid nursing home program who knowingly and willfully charges, for any service provided to the patient under the State plan, money or other consideration in excess of the rates established by the State plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State plan approved under this title, any gift, money, donation or other consideration other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the patient as a condition of admitting a patient to a nursing facility or intermediate care facility; or as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein is paid for in whole or in part under the State plan, shall be construed to be soliciting supplementation of the State's payment for services. Payments made as a condition of

admitting a patient or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid patient and shall be deemed to be out of compliance with 42 CFR 447.15 (1997).

IX. Definitions

Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

Agency for Health Care Administration : (AHCA), also known as the Agency.

Audit: Means a direct examination of the books, records, and accounts supporting amounts reported in the cost report to determine correctness and propriety.

Audit Adjustment: Means any adjustment within the Medicaid audit report or Medicaid desk review report on Attachment A.

Audit Finding: Means any adjustment within the Medicaid audit report or Medicaid desk review report not listed on Attachment A.

Desk Review: Means an examination of the amounts reported in the cost report to determine correctness and propriety. This examination is conducted from the AHCA reviewer's office and is focused on documentation solicited from the provider or documents otherwise available to the reviewer.

District: The agency shall plan and administer its programs of health, social, and rehabilitative services through service districts and subdistricts composed of the following counties:

District 1 - Escambia, Santa Rosa, Okaloosa, and Walton counties

District 2, Subdistrict A - Holmes, Washington, Bay, Jackson, Franklin, and Gulf counties

District 2, Subdistrict B - Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor counties

District 3, Subdistrict A - Hamilton, Suwanee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, and Alachua counties

District 3, Subdistrict B - Marion, Citrus, Hernando, Sumter, and Lake counties

District 4, Subdistrict A - Baker, Nassau, Duval, Clay, and St. Johns counties

District 4, Subdistrict B - Flagler and Volusia counties

District 5 - Pasco and Pinellas counties

District 6, Subdistrict A - Hillsborough and Manatee counties

District 6, Subdistrict B - Polk, Hardee and Highlands counties

District 7, Subdistrict A - Seminole, Orange, and Osceola counties

District 7, Subdistrict B - Brevard county

District 8, Subdistrict A - Sarasota and Desoto counties

District 8, Subdistrict B - Charlotte, Lee, Glades, Hendry and Collier counties